Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NUEVA VIDA BEHAVORIAL HEALTH 5555 FREDERICKSBURG RD. STE 102 SAN ANTONIO, TX 78229	MFDR Tracking #: M4-10-4631-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: NEW HAMPSHIRE INSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a position statement in accordance with rule §133.307.

Amount in Dispute: $90.00

PART III: RESPONDENT'S POSITION SUMMARY

The Respondent did not respond to this dispute.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
8/11/09	90885	N/A	$90.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 2/15/10 was the only EOB submitted by the requestor. It does not contain the 2nd page with the denial reasons.

Issues

1. Did the requestor submit this dispute in accordance with 28 Tex. Admin. Code §133.307?
2. Is CPT code 90885 a bundled code per Medicare?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to rule §133.307(c)(2)(A)(B) Provider request. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. The request shall include: a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. The requestor submitted two copies of the bill marked "request for reconsideration". There is no original bill submitted in the dispute. The requestor submitted only one page of a two page EOB. No other EOB's were submitted. The one page EOB does not list the denial reasons. Therefore, the requestor did not submit this dispute in accordance with rule §133.307.
2. The requestor billed CPT code 90885. The description of this code is as follows: Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes. The American Medical Association (AMA) further clarifies that this code is used when a clinician is asked to evaluate hospital records and develops a report for other agencies or individuals. It may also be used to report the evaluation of certain psychiatric reports, especially psychometric testing. Another use of this code is to report a records review requested by a peer review committee or for retrospective reviews requested by medical management companies. Pursuant to 134.203 (b)(1) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. The Medicare fee schedule lists this code with a status "B" indicator which means that payment for this code is always bundled into payment for other services not specified. Therefore, reimbursement for CPT code 90885 is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

		12/14/10
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.